TASC

Technical Assistance and Services Center

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Topic: Questions and Answers on the BBA Refinement Act

Background

The Balanced Budget Act (BBA) of 1997 included the Rural Hospital Flexibility Program (often called the "Flex" program) and created a new hospital designation – Critical Access Hospitals (CAH). BBA 1997 also required the development of a prospective payment system for outpatient services, analogous to the DRG payment system for hospital inpatients. The Balanced Budget Refinement Act (BBRA) passed by Congress in November 1999 changed the Flex program and provided rural hospitals with financial protection from the new outpatient prospective payment system (OPPS). These changes have a major impact on rural hospitals and State Flex program operations and may prompt States to modify their CAH implementation strategies.

In December 1999, TASC convened a work group of rural hospital technical advisors and other CAH experts[1] to identify how the BBRA may affect implementation of the Flex Program. The meeting led to a series of technical briefings that TASC will disseminate to State programs. This is the first of these briefings. For a description of BBRA changes beyond those impacting the CAH program, States are encouraged to read the Rural Policy Research Institute (RUPRI) report prepared by Keith Mueller and the Rural Health Panel (on-line at www.rupri.org). Regulations for the BBRA had not been issued as of the time of this writing. Readers should be aware that authors have interpreted certain provisions of the BBRA and that the final interpretation will rest with HCFA.

[1] Work group participants included: Jerry Coopey (Federal Office of Rural Health Policy), Bob Ellis (Westport Group), Brian Haapala (Northland Health Group), Terry Hill (National Rural Health Resource Center/TASC), Steve McDowell (Rural Health Consultants), Ann Miller (National Rural Health Resource Center/TASC), Paul Moore (Atoka Memorial Hospital), Eric Shell (Northland Health Group), Val Schott (Oklahoma Office of Rural Health), Tom Sipe (Kansas Hospital Association), Karen Travers (Westport Group), and Tony Wellever (Delta Rural Health). This briefing is based on the input and review of these experts. TASC has made every effort to represent the consensus opinions of this work group. This briefing may not represent the opinion of each participant.

Questions and Answers

How does the change to the length of stay (LOS) requirement – from a 96-hour limit to a 96-hour average – impact implementation of the CAH program for hospitals?

The change will likely increase interest in the CAH program among those hospitals already considering CAH, and larger rural hospitals may now consider the program. The LOS is "determined on an annual basis," and the provision is currently in effect.

The State Flex program may find it useful to separate the two types of hospitals because of their different support needs: Type A and Type B.

- "Type A" hospitals are facilities that easily fit within the CAH guidelines. In general, these hospitals will have an average LOS of less than 4 days and an average daily census of 10 or less. For these hospitals, the decision to convert is made easier because very few (if any) clinical changes would be required to meet CAH guidelines. The CAH feasibility study should determine the financial benefit and community impact.

- "Type B" hospitals are generally larger facilities that would not have considered the CAH program without the change to a 96-hour average LOS. These hospitals will have an average daily census of 10 or more (although there is no upper limit, most hospitals with an average daily census of 18 or more will likely not consider CAH) and an average LOS of more than 4 days. Aside from management statistics, these facilities generally provide a different mix of primary and more complex types of care. In addition to the financial and community impacts, CAH feasibility studies for these hospitals will need to determine the impact of the acute bed limitation and specify clinical management approaches needed if the hospital were to become a CAH. For example, these hospitals need to characterize the type of cases (generally) or patient admissions (specifically) exceeding a 4-day LOS, and the frequency of their occurrence in the case mix.

This categorization is a way to distinguish between the two types of hospitals for the purposes of CAH feasibility assessments. TASC is preparing a briefing that will provide additional recommendations on these issues.

Does the change to the 96-hour average length of stay (LOS) impact any of the State Flex programs?

The LOS change may alter hospital incentives for developing networking agreements. While BBA 1997 mentions CAH networking with larger hospitals, it does not require this networking (as long as one network is developed in each state). However, implied in the 96-hour limit per admission is the need to develop transfer agreements with hospitals to accept those patients needing a length of stay longer than 96 hours. This need is decreased by the change to an average of 96 hours. This is complicated by the fact that the BBRA did not change a number of related regulations. For example, under the previous rules, physicians were required to certify, upon admission, that a patient can be treated and released (or transferred) within the BBA 1997 96-hour limit. Until the CAH regulations are revised to account for the BBRA, it is unclear how these issues will play out.

The TASC Work Group fears that hospitals will place less emphasis on networking and miss some opportunities that networks can offer, both for transfers and for other agreements, such as credentialing and quality assurance. This places a greater responsibility on State Flex programs to provide leadership in building networks that are more sophisticated than agreements limited to patient transfers. TASC will provide a briefing in the future to assist in this activity.

What is the "election of cost-based hospital outpatient service payment plus fee schedule for professional services" option for CAHs?

This option combines cost-based payment for facility payment with the Resource Based Relative Value Unit fee schedule for professional services. This provision will allow the hospital to handle the billing for physicians, physician assistants, and nurse practitioners. Aside from reducing the administrative burden of its medical staff, it is unclear how the provision, as passed, will benefit CAHs. In fact, combining the two reimbursement methods onto one bill will make it very difficult for hospitals to determine the proper amount of the patient co-payment. This alternative is available to CAHs in their first cost reporting period after October 1, 2000.

Why was this option included if it does not directly benefit CAHs?

Drafts of the BBA 1997 changes specified that outpatient services be reimbursed on the basis of cost, defined as including both the facility and professional costs. This is often referred to as the "all-inclusive" option. The wording was changed very late in the preparation of the legislation. While there is no clear statement of the intent of the changes, the Conference Report specifies that both professional and facility costs be included in the "all inclusive" reimbursement rate.

The TASC Work Group will soon issue a recommendation on how the legislation can be fixed both in the calculation of the rate and in the effective date. Until such time, CAH evaluations should model the cost-based reimbursement methodology included in the existing regulations. Hospitals seeking to maximize their position under the CAH program may also choose to have financial modeling and examine the "all-inclusive" reimbursement rate based on inclusion of both facility and professional costs in the outpatient reimbursement.

Are there other advantages for the CAH if the current language reflected the EACH/RPCH "all inclusive" methodology?

Yes. The "all-inclusive" reimbursement option provides significant advantages in community-wide networking. The EACH/RPCH outpatient methodology encouraged local network by providing cost-based reimbursement for outpatient services. This enhanced reimbursement provided an incentive for community providers to network under the CAH umbrella through multiple arrangements—merger, acquisition, contracting, etc. By not changing the BBA 1997, community providers will not be able to access the enhanced reimbursement through the CAH. Given this, the lack of change undermines one of the basic networking goals of the CAH program.

Rural hospitals are "held harmless" from the impact of the new outpatient prospective payment system (OPPS). Does this mean hospitals can ignore OPPS?

Hospitals with 100 beds or less are "held harmless" until January 1, 2004, from the new outpatient prospective payment system (expected to be implemented in July 2000), but "held harmless" is not the same as "not affected." The provision does not appear to relieve

rural hospitals from the costs associated with OPPS preparation, which may require additional billing coding staff. For example, two major costs are information systems and staff training. Billing systems will need to calculate co-payment on the new payment system versus as a percent of charges. Also, OPPS requires hospitals to code procedures (which will include 346 new codes) more thoroughly and completely. This requires staff training in all hospital departments interfacing with outpatient services.

It is unclear what level of interim payment that hospitals falling under the "hold harmless" will receive (i.e., the payment a hospital receives until the year-end "settlement"). One alternative is a payment rate that is based at OPPS levels. The hospital may be able to negotiate a higher interim payment rate with the Fiscal Intermediary. Because the OPPS payment rate will be less than the current rates for most rural hospitals, payment at this level may lead to severe cash flow problems until the hospital's settlement is received.

Considering both the preparation expense and other issues, exemption from the OPPS model should continue to be considered an immediate and relevant consideration by hospitals interested in CAH designation.

The BBRA specified grants of up to $50,000 for helping rural hospitals prepare for outpatient prospective payment. Won't this offset hospital costs?

Although the BBRA specified a program for grants of up to $50,000, an appropriation was not made to support this grant program. First, the cost of preparing for OPPS may well exceed the grant amounts specified by Congress. Second, and more important, the Federal Office of Rural Health has indicated that resources from the existing grant program supporting development of CAH would not be applied to the OPPS issue. Additional Congressional action and an expeditious grant process would be required to make funds available in time to assist hospitals in preparing for the projected July 2000 implementation of OPPS.

Why was there a change in the collection of co-payments specified for lab services?

CAHs are no longer required to collect co-payments for reference lab services. This levels the playing field with all other hospitals providing lab services that do not collect patient

co-payments. This change took effect upon enactment and existing CAHs should be notified.

Are there any other key provisions of the BBRA in terms of implications for the CAH program?

- The number of eligible hospitals was expanded to include for-profits, hospitals closed within the past ten years to re-open as CAH, and currently licensed health clinics or health centers that were created by downsizing a hospital. This provision took effect upon enactment, but it will likely impact few hospitals. In some situations, States may face criticism related to the distribution of grant funding from hospitals/associations that do not believe for-profit companies should be eligible for grant assistance. Also, there is concern regarding re-licensure for hospitals closed within the past ten years and ensuring buildings are up to current codes.

- Hospitals in rural census tracts of Metropolitan Areas (MAs), as well as areas designated by the State as rural, are now eligible for participation in the CAH program. The impact of this provision will vary state to state. To the extent that States take advantage of the opportunity to designate rural areas, the number of CAH-eligible hospitals may increase. This provision took effect January 1, 2000. States need to reevaluate the CAH candidate hospitals, given the flexibility to expand the definition of rural. In order to take advantage of this flexibility, States will need to develop state-based criteria for a definition of "rural" and/or criteria for the definition of a facility designated as a "rural" facility.

- The costs used to determine inpatient payments for Sole Community Hospitals (SCH) can be "re-based" to the hospital's 1996 costs over the next four years (2000-2003) for certain SCH hospitals. A large proportion of potential CAHs are now SCHs. For these hospitals, the effects of this provision should be included in CAH financial impact analyses. This change impacts cost reporting periods beginning October 1, 2000.